DEPARTMENT OF DEFENSE

T R I C A R E
MANAGEMENT ACTIVITY

TRICARE DUAL ELIGIBLE FISCAL INTERMEDIARY CONFERENCE

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TRANSCRIPT OF TAPE RECORDED MEETING

PANEL & SPEAKER APPEARANCES

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[The tape recorded proceeding as set forth on page one is transcribed as follows:]

MR. RUBIN: My name is Brian Rubin. I'm the program project manager for the T-NEX contracts. We want to welcome you to our pre-bidders conference this morning for the Tricare Dual Eligible Fiscal Intermediary Contract.

You've got to wonder how we come up with those names sometimes. If I hadn't been part of that I could probably be a little more critical of our title.

We've referred to this as TDEFIC and we've referred to it as dual eligible contracts. But I think regardless of what we call it, this is one of our most important contracts that we've got in the suite of T-NEX RFPs that's out on the street.

Obviously the population that we're attempting to serve here is extremely important to the MHS, and in keeping our promise to our beneficiaries.

We have a couple of distinguished guests I'd like to introduce before we begin this morning. We're very pleased to have the Principal Deputy to the Assistant Secretary of Defense for Health Affairs, Mr. Ed Wyatt with us this morning.

Our Deputy Assistant Secretary for Health Plan Administration, Rear Admiral Carrato is with us today. And Major General Nancy Adams, who is the senior advisor to Dr. Winkenwerder is also with us. As well as the Tricare contracting activity, Mr. Ron Richards.

Also distinguished is our panel here today. To my far left is Doris Navarro. Doris will be the contracting officer for this solicitation.

For those who have not dealt with Doris in the past, she was the contracting officer for a couple of our managed care support contract awards. I think Region 2/5, Region 3/4. Most recently Doris was the CO in Region 1, and we drafted her for this solicitation. So Doris brings a lot of experience to the table.

To her right is Mr. Tom Frey. Tom's got over 20 years experience with us, and he's the project officer for this particular contract, and later he'll go through the requirements and explain to you what we're trying to buy here.

To my immediate left is Mr. Steve Lillie. Steve is out of our Falls Church Office, and was one of the co-program managers for the implementation of Tricare for Life, and very instrumental in coming up with some of the policy that appears in the current contracts and what you'll be bidding on. And

you'll hear from Steve in a little bit.

Pull up the agenda. Very quickly, a couple points that I want to touch on here.

Steve is going to give us an overview of Tricare for Life. I think it's very important that everybody understands where we've been, so you understand what's in this RFP, why some things are in it, and a little bit of history.

For those of you that were here yesterday, we had an IT conference. And if it didn't come across clearly to you, the background on that conference, and why we decided to have it, was questions that we were getting from new players.

And I think it hit us pretty hard that we assume some things sometimes that people may not always know how the interworkings of DoD and the MHS happen. We're not going to make that mistake here today.

We're going to give you the history on how we got to where we are, with the Tricare for Life. Tom will then go through the requirements. But these presentations are what we think you need to hear to bid.

But the purpose -- and Doris will talk about this a little bit, too -- the purpose of these pre-bidders conferences is to provide feedback from you to us on questions that you have, and for us to provide as many answers as we

possibly can, and we'll take questions in any shape or form.

You'll hear that a couple times today, but I want to make sure everybody's comfortable in doing that.

And of course, questions and answers. We don't have any time on this. We have no idea how long this will take. We'll be here all day, if we need to.

It's very important to us that you understand what we're trying to buy, and you can prepare good proposals for us. So at this point, I'm going to ask Doris to come up and give us the rules of the road here.

MS. NAVARRO: Thank you, Mr. Rubin. Can everyone hear me okay? Great. Good morning, and welcome to our pre-proposal conference.

If you have not signed one of the sign-in sheets that's located right outside the conference room, I ask that you do so sometime during the day. This includes both government and contractor personnel.

We also have a folder for the contractor personnel. This includes a copy of the agenda for today, and the web site information for this solicitation.

In the folder is also a name tag. You may wish to fill this out and place it on your person. This will help us and others know who you are. And it may assist you in

networking and partnering with other participants at this conference.

The folder also includes a few note cards. These note cards are to be used to write any question that pertains to this conference, or the RFP. I encourage you to use these note cards.

However, if you wish to ask a question verbally, you may do so. I will ask, though, if you have a verbal question, that you approach one of the podiums.

With regard to the written questions, we do have people available to collect them. Simply raise your hand and someone will pick them up, or we will -- you may drop them off in one of the boxes by the door and we'll collect them during our break. If you need some additional cards, simply raise your hand and someone will provide them to you.

During the break, I ask that contractor personnel please refrain from discussing or asking the government personnel any questions with regard to this RFP. All discussions and questions should be addressed to our panel in this conference.

After the break, we will make every effort to answer your questions here today. In the event that we are unable to answer a specific question, because it requires some

additional research on our part, we will read that question here today and provide a response to you on our web site.

This conference will be transcribed and the transcript will be available on our web no later than seven days from today. We will also include a list of the conference attendees and copies of the slides you see today on the web site.

Now with that, I do want to go over the purpose of this conference. The primary purpose is to permit you, the offeror, to gain a better understanding of the objectives of this acquisition.

And the way it will be conducted, specifically, it provides the opportunity for you to ask questions, after you have examined the solicitation document. This will allow the government an opportunity to clarify the requirements of the RFP.

This will allow the government an opportunity to identify any ambiguities, errors, or omissions to the solicitation document that we can later correct in a written amendment.

This will allow the government an opportunity to resolve any questions on Sections L or M, which will be used to evaluate the proposals.

And finally, this conference will provide you with further insight into the size and complexity of this acquisition, as well as its attendant risks before you make your final decision to submit a proposal.

Please be advised that nothing that is said in this conference will qualify or modify the terms of this solicitation document, unless it is formally amended in writing.

And that concludes my administrative comments and the purpose. Do you have any questions? Thank you. I'll turn it back over to Mr. Rubin.

MR. RUBIN: Thanks, Doris. I assume you all are paying attention to the web site, or you wouldn't be here. I can't encourage you enough to check that thing on a daily basis.

We're getting questions, we're providing answers, updates, on everything that's pertaining to this RFP. That is working very well, but you've got to help us a little bit. You've got to pay attention to what is happening on your end.

This is one contract out of many that's under an umbrella known as T-NEX. And to give you a big picture view, if you will, of how this fits and everything else that's going on in the department under T-NEX, Mr. Wyatt is going to give

us a bit of an overview.

MR. WYATT: Well, good morning. Mostly what I wanted to do was just take a couple minutes of your time to thank you on behalf of the assistant Secretary of Defense for Health Affairs, Bill Winkenwerder, for making the effort, for being here, for showing up and for participating in the process, because as you all know, and we certainly know, we can't get this done without you.

We need you at the table. If we're going to get a contract an agreement and move forward, it's necessary to bring you to the table to bring those negotiations going.

In the process of developing this whole suite of T-NEX solicitations, we have made a, I think, pretty good effort to involve not only health care industry -- and in particular through Bill Winkenwerder and Dave Chu, the Deputy Secretary of Defense for Personal Readiness, and both of our bosses -- meeting with several of the leaders in industry, getting some good input on what's working, what's not working, what are the trends, trying to get a little bit out front of the trends with the next generation of contracts.

And of course, our primary reason for doing all of this is to take care of those beneficiaries of ours out there, the soldiers, sailors, airmen and marines and their families,

retirees who have already served so well, and their family members.

The government's development team for this entire suite of contracts really is somewhat different than it has been in the past, because as you know, one of President Bush's agenda items for this administration is to get the different parts of the administration working more closely together.

For us, that means a much closer working relationship with our colleagues, friends and partners over in the Department of Veteran Affairs, and the other uniformed services, including the Coast Guard, NOAA, and the PHS.

It's just this simple, frankly, and as all of you know, also, that complex. The whole point here is to try to develop a suite of contracts that are simpler and provide better financial incentives.

Frankly, the goal, the financial incentives, are linked, we hope correctly, to enhancement of customer service. In the final analysis, that's what we're looking for. That the rewards come on the customer service side of the house.

We all know we've got to deliver the benefit. We have to do it in an economic -- as economic and efficient fashion as we can. But the focus here, on all of these contracts, really in the final analysis, is on our customers.

And also we're very interested in having a suite of contracts that provides the government the flexibility to move the Military Health Care System forward from its current structure to one which is more integrated across the system internally, and which it gives us some flexibility to deal with our colleagues and the VA and the other departments.

I'm not going to spend much time on the suite of contracts itself. As you already know, the one we're going to focus on today is the Tricare Dual Eligible Fiscal Intermediary Contract. All of the other contracts are in various stages of solicitation, either preparation, or under bid.

And then we'll do Steve Lillie's slides here, and then Tom Frey, and then the pricing slides. Are there any questions about this slide in particular? This is Steve Lillie. This is Tom Frey.

Please know that we're glad you're here. Don't leave here not having asked the question, either personally, in writing, or submitting it to us on the web site at some point.

Our goal is to help you. At this point, now it's about you. Get in a position to be able to provide a quality proposal to the government, because we want you at the table.

And we will do what we can to get you there.

We have a fairly disciplined process in place that purposely moves the timeline along for getting these contracts awarded. But a quality contract is more important to us than an artificial deadline. We all know there are some windows out there we have to meet for a variety of reasons. But it's the quality solicitations that we want.

Don't leave here not having told us something that we can do to help improve the quality of those solicitations. Thank you all very much. Brian.

MR. RUBIN: Thank you, Ed. To put this contract in perspective a little bit, Steve's going to talk some history on how the Tricare for Life benefit came about, and what we've been through the last year in implementing this.

Our current managed care support contracts were fairly large to start out with. But we added about a 15 percent increase in our population. I think we normally talk about 8 million beneficiaries served. We added about 1.5 million over 65 beneficiaries. So 15 percent or so increase in our eligibles.

It doubled our claims volume, and it doubled our dollar payout. So if you think about what we've been doing within the past roughly 35, 40 million claims a year, we

expected this to double that, and that's coming about.

So this is no small piece of business, and has had a huge impact on the Tricare program. Having said that, it's also been a huge success for our over 65 beneficiaries, not only with the pharmacy benefit, but the med/surg benefit that stood up a year ago in October.

To give you more detail on that, again, is Mr. Steve Lillie. As I mentioned earlier, Steve was very instrumental in pulling together the policy for Tricare for Life, and also in terms of actually getting it implemented in the last year. Steve.

MR. LILLIE: Thanks, Brian. Can you all hear me okay? I guess so.

A couple of the speakers, Mr. Wyatt and Mr. Rubin have mentioned sort of the context for this. Obviously it's part of the umbrella of T-NEX contracts. A very significant one, as they mentioned.

For those of you -- many of you are familiar faces, but for those of you who are coming to the Military Health System and Tricare for the first time, it may be helpful to take just a moment to describe those terms. We talk about the Military Health System, tend to focus on the hospitals and clinics that are operated by the uniform services worldwide.

Tricare is the term that we arrived at for the -- it's been used in various ways. But one way that we use it is for the health care benefit that active duty members, their families, retirees, people who have served 20 years or more in the military, their family members and survivors of those active duty members, or retirees who have died, all of those people are in Tricare at this point. And we've used that term, generally, for their health care benefit.

That benefit includes both access to care in military facilities, to the extent that space is available there. And it includes varying levels of civilian health care coverage. And we'll talk a little bit more about how that particularly has changed under Tricare For Life, for the military retirees and survivors and family members over age 65, who are Medicare eligible.

The Military Health System, just so you know, does more than just provide that health care benefit. It really does serve a dual mission, support for war fighters, force health protection and providing medical services in some pretty awful places around the world. And deliver that peacetime benefit in many cases using the same suite of providers and facilities.

The infrastructure that's there for wartime isn't

always needed, so it's made available. And much of the health care that's delivered in the military health system is in what we call the direct care system, supplemented by a peacetime health care benefit. Next slide, please.

Oh, I forgot that I have one of those fancy slides that slide in. I think this is the only one that does, though.

Some have viewed this as two significant improvements in health care benefits. The introduction of Tricare, which was an attempt to better integrate care provided in the military health care facilities around the world, with the peacetime health care benefit.

And those managed care support contractors that you hear about have served to do a lot of the integration between care in the military facilities and civilian health care.

Up until the advent of Tricare, largely a beneficiary would seek that space available care in the military hospital. If it was not available, they might be given a list of providers who usually dealt with what was called CHAMPUS at that point. But were basically left to their own devices to obtain civilian health care.

Now there are many more support mechanisms to help beneficiaries move back and forth between military facilities

and a network of civilian providers established by the managed care support contractor. That really came into fruition beginning in 1995, and rolled across the country over the next several years.

Some very significant changes arose with the National Defense Authorization Act of 2001, which was passed October 30th, 2000. Signed into law then.

The most significant two pieces of that were the elimination of co-payments for active duty family members who were enrolled in the HMO option in Tricare, called Tricare Prime. Instead of having nominal co-pays for care, when they obtained care under the program, they had no co-pays anymore, which obviously was a major benefit enhancement for them, and a major challenge for the system to figure out how to deal with that.

The other big thing is the one that we're focused on today, which is the introduction of Tricare for Life, so-called. Basically, Tricare began paying benefits secondary to Medicare for people over 65. That was a pretty landmark change, really, for our system.

Up until the enactment of this provision, people who became eligible for Medicare, Part A, at age 65, lost their

civilian health care coverage from DoD. We'll talk in a few minutes about why that was a significant change for them.

But basically, when the original CHAMPUS was enacted for retirees back in 1966, the thought was that the combination of civilian coverage, plus access to care in MTFs would be great for people under 65.

And once they hit 65, then they'd have the combination of access to care in military facilities, plus Medicare. So they wouldn't need CHAMPUS anymore.

Some things changed over the years that made that not work quite so well for them, so we arrived at the enactment of Tricare for Life, where in addition to having Medicare, and in addition to having access to care in military facilities, now benefits are payable by Tricare secondary to Medicare.

If you hit the button again, and I think it will grow that a little bit more.

Basically, there's very little doubt that this is the major change, as Brian said. It changed our contracts in a very significant way. It changed the budgetary structure in DoD in a pretty big way, and it certainly has enhanced the lives of military seniors.

They made a very good case to Congress that they

were promised some things, in their military service, and truly earned some substantial benefits. And this has delivered on that. DoD has always felt the commitment.

The military leadership was supportive of this kind of thing, because they feel very strongly that recruitment and retention is enhanced by keeping commitments to people who have served in the past. And I think there's a lot of merit in that view. Next slide, please.

Talk just briefly about where this came from. Why this situation arose that Medicare plus space available access in military facilities really wasn't good enough anymore.

There were a couple of factors. One is that we pulled back in the number of military facilities in a pretty substantial way. Those direct care military hospitals and clinics.

The other is that this was the growing part of the DoD beneficiary population, and thirdly, just changes in medical practice. An increased reliance on prescription drugs in the treatment of seniors has resulted in a growing spotlight, if you will, on that gap in Medicare. The lack of a Medicare prescription drug benefit in an outpatient setting. Next slide, please.

And this just gives a little bit of a graphic

depiction of what happened. Over a little more than ten years, the number of military hospitals closed -- shrank by about half. Our beneficiary population went down a little bit, as the active duty force was shrinking a little bit in that time frame.

But the 65 and over population was growing dramatically. And it has grown since then to about 1.6 million people, and will continue to grow for about the next 15 years a little bit more. I think it's supposed to hit about 1.8 million people, but that includes, by the way, both military retirees and spouses and survivors in that number there, in the 1.6 million or so that we have right now.

Just as an aside, there are the additional people covered by the contract, or people who are under age 65 and Medicare eligible, as well as being eligible as a uniform services beneficiary. There are roughly 50,000 people in that category, and obviously people make the transition to Medicare eligibility, and sometimes lose that eligibility that they had on the basis of disability or end-stage renal disease, but that's another population covered under this contract.

All of these factors created a lot of interest on the part of the administration, the Congress, beneficiary groups in finding a way to enhance the benefit for Medicare

eligible, military or uniform services beneficiaries. Next slide. So we tested some things, in true fashion.

Actually, the first thing wasn't even a test. The pharmacy benefit in -- I try to avoid acronyms, but BRAC is a nice one; the base realignment and closure, which many people have heard of in one fashion or another, because it affected so many communities across the country.

One of the factors there was that military retirees may have chosen to settle in a particular location because it was their last duty station, or whatever. One of the factors may well have been access to a military hospital.

The Congress determined that it was appropriate to offer a benefit, a pharmacy benefit to those who had been adversely affected by the closure of a military hospital, which, you know pharmacy is often a big part of the operation there. So they enacted this provision.

So in places like Ft. Worth, where Carswell Air Force Base closed, the government offered a retail and mail order pharmacy benefit to the military retirees there, over 65, who either lived in the location, or could demonstrate that they had used that military pharmacy. That program was in effect in quite a number of sites, obviously filling in the significant gap, if you will, in Medicare coverage.

We also wanted to test the number of ways to enhance the benefit that went beyond just the pharmacy coverage. Tricare Senior Prime is basically military operating a Medicare HMO. And I'll talk a little bit more about that program in a few minutes. That was initiated in 1998.

We also tried out some different programs to basically create a Medicare supplement for people. One was sponsoring their enrollment in the Federal Employee Health Benefits Program; locking them out of military health system coverage, but paying a premium for them. And we paid a premium at the same level as is paid for federal employees and annuitants under FEHB.

That program is ending shortly, and has never really achieved the kind of enrollment or participation levels that might have been expected, and certainly at this point, has been supplanted by the enactment of the Tricare for Life benefit. But it was a different way of trying to do the same thing to supplement Medicare.

The Tricare Senior Supplement was just a way to directly offer people an opportunity to buy a Medigap plan, essentially sponsored by DoD. The premium was about $600 a year for a beneficiary to buy into that. That operated in a couple of sites. It didn't attract much, either.

The pharmacy pilot program was just offering a pharmacy benefit, just like the BRAC site pharmacy, but charging people a couple hundred dollars a year to get a comprehensive retail and mail order pharmacy benefit.

And then finally the McDill 65 demonstration, so-called, was a program to -- really a hybrid sort of thing that makes some sense on its face, to offer seniors the opportunity to sign up for primary care at a military hospital, to get a doctor at the MTF, as we call it, the Military Treatment Facility. To have a doctor there for their primary care needs.

That doctor would provide primary care, would refer them within the hospital, if care was available there. If the facility couldn't supply their needs, they'd just go to a civilian provider and use their Medicare benefit.

DoD was not taking on risks or making a commitment to provide comprehensive services to that patient. Just the care that DoD could provide within the four walls of the military facility. Next slide, please.

I said I'd talk a little bit more about Tricare Senior, because that really did generate a great deal of interest. A lot of energy was put into that by the Medicare program, by DoD.

On its face, it's a way for Medicare beneficiaries, who happen to also be uniformed services beneficiaries, to use their benefit where they please. They've earned a Medicare benefit, but by statute, the Medicare trust funds cannot pay a federal facility. So when a Medicare eligible beneficiary goes to a military hospital, there's no payment for that care made by Part A or Part B of Medicare.

The Tricare Senior Prime demonstration was an amendment to the Social Security Act, to Title 18, which enabled DoD to sponsor military HMOs, if you will, Medicare HMOs in six sites.

We actually went through the qualification process, and became federally approved Medicare Plus Choice plans, 'cause this was enacted the same time as Medicare Plus Choice. They were technically Medicare HMOs. They were M+C plans in the six sites, and could get capitation payments, a little bit lower payments than the standard M+C payment, if you can believe that.

And also, we had to provide our level of effort, if you will, that we had already been providing for Medicare eligible beneficiaries at the site, before any funds would flow from the Medicare Trust Funds to the facility. Next slide, please.

Very briefly, it was in six places, as I mentioned, a variety of sizes of facilities. But in all cases, the enrollment was to the military facility. The patient had a primary care doctor or provider in that military facility.

We modified the managed care support contracts to use the Tricare networks surrounding that military facility, to refer care that the hospital or military facility couldn't provide. So skilled nursing care, some specialty care, varied by site.

You have some very large medical centers there. For example, Wilford Hall in San Antonio, with very comprehensive services available, ranging on down to Dover Air Force Base Hospital, which had primary care and a few beds, and a little bit of other care, but had to rely heavily on the civilian side. So it did present some interesting variations.

The eligibility requirements were basically very similar to standard M+C or Medicare HMO requirements. It's other than the dual eligibility. Next slide.

First word to say about this program is that it has ended last December. It was extended one year, to provide coverage for the 35,000 or so people enrolled in it, through until Tricare for Life was implemented. And we've provided a means for these people to maintain their relationship with

military facility providers.

The basic findings up there are pretty straightforward. Beneficiaries really likes this program. Consumer Reports, in fact, happens to be doing ratings of Medicare HMOs and it just so happens that San Diego was a place they did that, as well as Colorado Springs, as I recall.

And the benefit offered under TSP far outstripped any of the benefits offered by Medicare HMOs, principally because of the pharmacy benefit, whereas most Medicare HMO pharmacy benefits are like the Medicare supplement benefits, and have a stop loss for the plan built in.

Our benefit is a comprehensive one with no cap on what the plan will pay for prescription drugs, or the extent of the coverage during the year, which really puts us off the charts in terms of benefit. And of course, it raises the costs, too. But that's okay.

We did learn a good bit about the provision of health care services to seniors. We learned some things about what not to do. Basically not to try to operate under two different sets of managed care rules in the same facility, because these people in military hospitals were operating a Tricare program with a set of rules, as well as trying to

operate under the oversight of the Medicare -- the Hickford Regional Office at that point.

There are continuing discussions with Medicare over the issue of how to better integrate the care under Tricare for Life, now, and the care in military facilities with Medicare benefits.

As Mr. Wyatt said, we've got increased relation interaction with the Department of Veteran Affairs, and the same applies to the Department of Health and Human Services center for Medicare and Medicaid services, because we've got over a million and a half people now that we're jointly responsible for. Next slide.

So finally we get to TFL. The National Defense Authorization Act included Section 712, which was technically a very simple change.

Up until then, as I said, people who hit age 65, who were uniformed services beneficiaries, their CHAMPUS entitlement -- and it is an entitlement -- their CHAMPUS entitlement ended. They were no longer entitled to payments for civilian health care services. They received payments from DoD.

Tricare for Life, the statutory change just said, eliminated that aging out of CHAMPUS, if you will. And that's

a change to Title 10, Section 1086-D, if you want to look it up. But it's a very straightforward change.

In the same section, the under 65 dual eligible persons, they were locked out of CHAMPUS, up until about 1991. There's a similar provision there that says if you're eligible for Medicare and enrolled in Part B, you continue your Tricare coverage, your CHAMPUS eligibility, technically.

Company provisions, as it notes there on the slide, the Tricare for Life took effect October 1st, 2001. The Senior Pharmacy Program, which has slightly different eligibility requirements in that persons who turn 65 prior to April 1st, 2001, didn't have to have Part B, to qualify for this senior pharmacy benefit. That was implemented on April 1st, 2001.

And Section 713 establishes something that just started this week. Started operational, although the planning and so forth has been going on for quite some time.

It established a fund separate from the normal appropriations process that DoD funds the health care benefit with. It established this Medicare eligible military retiree health care fund, which is sometimes called the accrual fund.

And that fund is provided money, both from -- contributions from the Treasury Department, from the U.S.

Treasury, for the accrued liability of people who have already retired or served on active duty, as well as an annual contribution from the Department of Defense for people currently serving on active duty.

So it has the substantial balance in it to pay the significant benefits that are included under Tricare for Life, and the Senior Pharmacy Benefit, and it will pay for the care rendered to Medicare eligible folks in military facilities as well.

You'll note, I mentioned earlier, this was enacted October 30, 2000, and we had about five months or so to do the pharmacy benefit, and about 11 months to do the Tricare for Life benefit. And as you may know, if you've dealt with government activities much, we don't usually move quite that fast.

We had to do some pretty fast footwork to get this in place, and basically modify existing contracts for pharmacy benefits, and for paying claims. So we modified the managed care support contracts and the National Mail Order Pharmacy contract that we had in place, in order to provide these benefits in time to meet the statutory deadlines for them.

Now we're engaged, under T-NEX, in procurements that are focused just on those benefits for seniors in the case of

this TDEFIC procurement. Next slide, please.

The eligibility for this is pretty straightforward. They have to be a dual eligible, obviously, and they have to be enrolled in Part B of Medicare, which of course has a few land mines in it, because people who chose not to enroll in Medicare Part B at the time they became eligible -- they have to make an affirmative -- a declination, to opt out of Medicare Part B -- if they did that, then they face substantial penalties for signing up late.

There is an annual opportunity, however, to sign up for Part B, if you declined it at the time you became eligible for Medicare Part A.

There is a subset of people who never became entitled to Medicare Part A, because they lacked sufficient orders of coverage under Social Security. Those people have never lost their Tricare status. So we have people still eligible for Tricare, but not Tricare for Life, who are 80 years old, because they didn't work sufficient quarters under Social Security.

Those weren't affected by Tricare for Life. They had the same status right along. They never were excluded from CHAMPUS, if you will.

As I mentioned, there is an annual enrollment

opportunity from January to March, called the general enrollment period under Medicare. And what will happen with people who do that, and there will be a small number, they will be added into the population.

And we do a data match with Medicare to identify newly eligible people, either the folks aging in, or people who are signing up like this, to add them to the rolls. And it's a fairly straightforward process we're following. Next slide, please.

Benefits. We wanted to provide the level of customer service that really is the commercial standard here, the gold standard of a paperless process for the beneficiary. So we had our managed care support contractors, in implementing Tricare for Life, go to all of the Medicare intermediaries and carriers, and negotiate trading partner agreements with them to receive electronic crossover claims. So the large majority of the claims are electronic and are sent to us after processing by Medicare.

The benefit payments are fairly straightforward. The statute is pretty unequivocal that if the service is payable by both Medicare and Tricare, we pay the beneficiaries out of pocket costs remaining after the Medicare payment.

The basic coverage, then, extends to the Medicare

deductible, Medicare co-insurance, and yes, up to the Medicare limiting charge. So we pay up to the 115 percent of Medicare allowable that a provider who doesn't participate can build, which is really an excellent benefit for this group of beneficiaries.

For services that are not part of Tricare, I recall -- Donna Hoffmeyer is in the audience, in fact -- making it very clear that the intent was not to change Medicare and not to change Tricare. Merely to stand Tricare behind Medicare, for these beneficiaries.

So a service covered by Medicare, didn't magically become also a Tricare benefit, because of enacting Tricare for Life. So a chiropractic claim doesn't get any Tricare add on to the Medicare payment.

Similarly, Medicare didn't change, so it doesn't cover pharmacy for these beneficiaries. We're the primary payer for that, just as we're the primary payer overseas, where the Tricare benefit applies, and the beneficiary has cost sharing.

Offerors under this contract, of course, don't have to worry about the overseas claims, because those are being handled elsewhere. But it's helpful to understand that really when you think about it, when Medicare is not involved in a

service, or when Medicare limits are exceeded, it's basically the Tricare benefit and its attendant cost-sharing for a retiree that applies in these cases.

Similarly with pharmacy. These beneficiaries do face the pretty low Tricare co-payments for pharmacy; three and nine dollars for different situations. Next slide, please.

We went to great lengths to work very closely with the beneficiary groups. This is actually a tribute to the wisdom of the current Navy Surgeon General who had the foresight to say, "Maybe we should talk to them about this."

We started back about almost two years ago now, talking to beneficiaries about this new benefit. We faced a pretty good marketing challenge, because seniors had been educated pretty well that Tricare wasn't for them.

Once they hit 65, they could still use the military hospital, but they no longer could enroll in Tricare Prime, they no longer could get claims paid under CHAMPUS or Tricare, and that sort of thing.

Well, we had to undo a lot of that. Because I think the perception we heard from beneficiary groups was if you mailed them something that says Tricare, they're going to pitch it, because that doesn't apply to them anymore.

So we worked quite a bit with the beneficiary groups to get a lot of things into the retiree magazines, and so forth. We've done a lot of work on our web site, which has substantial information, even though most seniors don't really rely on the web for their information. They tend to rely on their retiree magazines. But we went both routes.

And we talked to them a lot about the message, about how to convey it. Most recently, we met on Tuesday, in fact. But it really was very valuable for us in terms of understanding the needs of seniors.

The other thing that we had to worry about a good bit was reaching out to people who had lost touch with the military health system. Since they didn't live near a military facility, there really might not be a reason to maintain their eligibility in the system. There was no real relevance for them.

So we did a lot of work with senior organizations, and doing mailings. Outreach to things like nursing home administrators, and state agencies on aging, and so forth, just to try to get the word out.

More than anything else, the military retiree community tends to be fairly close knit, and people look after each other, so there was a lot of word of mouth involved in

getting the word out.

The big issue here was that this was a transition. When I described those demonstration programs, other than Tricare Senior Prime, participation in those demonstration programs was a little bit lower than we might have expected, I think it's safe to say.

When I look back at those, I think it's because seniors had made their health care arrangements. They had decided what they were -- they had bought a Medicare supplement. They lived with the fact that they had no coverage beyond Medicare. They made arrangements to use a military hospital. Even if it was 200 miles away, they'd come up with a way to get their prescriptions filled there.

So offering them a temporary program, a three-year demonstration, or something like that, wasn't going to dislodge many of them from their benefit arrangements that they'd made.

Well, Tricare for Life is a whole different thing. It was passed by overwhelming majorities in both houses of Congress. It's not going away.

The accrual fund, the actuaries that run that have an amazing mind set. They're looking out 50 years and figuring out how to assure there's sufficient funds there to

pay all these benefits.

So we had to explain all that to beneficiaries, and help them make decisions that only they could make. We can't tell them to drop their supplement, or something like that.

But we had to carefully explain the benefits, and create an orderly process for them to let us know that they were going to drop their benefit on such and such a date; drop their Medicare supplement, or something like that, and rely on Tricare for Life. Next slide, please.

As an aside, and this really is an aside, because this doesn't affect claims processing at all in Tricare for Life, we set up a program in military facilities. There is a determination that it was not appropriate to offer the HMO type option of Tricare, Tricare Prime, to these new Tricare for Life beneficiaries, because we're the secondary payer, and it just doesn't make much sense to offer the -- try to manage the care, be a managed care plan for somebody when you're the secondary payer.

But we wanted to provide a way for them to gain priority access for care in military facilities. When we discussed it with the beneficiary groups their focus was, how can a person sign up and be assured he's got a doctor at the military facility? So if he calls, he can talk to his doctor,

or get seen by his doctor, if he needs to.

What we arrived at was a program called Tricare Plus. It varies from place to place. It's not offered at some military facilities.

It's dependent upon local capacity for primary care, in excess of that that's already devoted to active duty members and their families and other retirees under Tricare Prime. So if there's excess capacity, seniors and others who aren't enrolled in Tricare Prime, can sign up under this so-called Tricare Plus program.

It doesn't affect their civilian health care access at all. It's merely, "I've got a doctor at the military facility who will see me when I need to be seen." But it doesn't affect, as I said, Tricare for Life claims processing. They're still, if they use civilian care, they're going to go to a provider that's going to file a claim with Medicare, and it's going to cross over to the dual eligible FI contractor for payment.

There's about 137,000 people enrolled at MTFs across the country and in Europe under this program. So it has provided a measure of access to primary care at military facilities for these people. And we did let all of the Tricare Senior Prime enrollees, for example, those 35,000,

they had an established relationship under Tricare Senior Prime with a military provider.

So we transitioned all of them into this Tricare Plus arrangement so they could keep using the military facility for their primary care, if they wanted to. And we did that for some other programs across the country where people were impaneled to military providers, seniors were. Next slide, please.

There were some implementation issues inevitably. A lot related to this whole issue of time of transition. The -- we accidentally left off a bunch of people from the initial files that we gave to Medicare through sort of a technical glitch. It was called the "Claims Glitch," I think is what the name was we used. But fortunately it got fixed pretty quickly with an update to the file.

But what those people were faced with for the first several weeks of Tricare for Life was, they had to file paper claims, because Medicare wasn't going to go back and re-run all the claims once they had this additional set of eligibles. They have a lot of new claims coming in every day, and they're not going to re-run six weeks worth of data.

So that was sort of a minor disaster. Nobody lost benefits, but we had to explain to them and provide some

support on how to file a paper claim for this short period of time.

We did face the problem, as I mentioned, some people who had lost touch with the system. The eligibility system includes a bunch of people who weren't eligible right now, because it's got history in there.

And we had lots of people who had not updated their file. The rule is that for retirees, they don't have to renew their eligibility, but a retiree spouse or a survivor can do some things to lose eligibility for DoD benefits.

If a spouse divorces and doesn't meet some specific requirements to maintain coverage, they lose it. If a widow remarries, they lose their DoD benefits, their health care benefits. So the system includes requirements that they have to revalidate, reverify their eligibility every four years. Well, there were a bunch of people in the system that hadn't done that.

We became concerned about that, and in fact made a pretty extraordinary policy determination and implemented a special initiative to pay claims for those people who were technically not eligible on the presumption that they would be able to re-verify their eligibility. We sent them special messages, 'cause we were getting claims for these people

crossed over. We'd included them all on the crossover file to Medicare.

So we did a bunch of work this summer trying to get in touch with those people, and this was a good address compared to the -- because it was a current address from a Medicare claim, as opposed to a five, six or seven year old address from an outdated eligibility file that we had. So we were able to get a bunch of those people reestablished, and that initiative ended on September 1st.

As I mentioned the Medicare Eligible Military Retiree Health Care Fund did take effect this week, and that required establishing some rules of engagement of how the funds would flow, but not of much interest here, because that's all sort of behind the curtain from your standpoint. Next slide.

Some of the issues, technical issues we faced were that one might think -- and you probably know this better than we do -- one might think that Medicare has a pretty standard approach to things, and of course, it varies, so that our contractors had to deal with varying record layouts coming from varying Medicare claims processors, in that electronic crossover process, for example.

We have a lot of people aging into this program, obviously. So we have to do updates to the eligibility files on a regular basis. We do that monthly, and then we clean the whole file every six months.

One of the lessons from this was that for our managed care support contractors they had to implement a slightly different process than they used for dealing with other health insurance where Tricare is the secondary payer. And that caused a little bit of difficulty in working through that.

Since under this contract, this will be a new activity and won't really involve that other health insurance, this will be built on the basic premise of Tricare for Life of paying out of pocket costs after Medicare. So that shouldn't be an issue here.

One of the special situations we faced was where Medicare includes the opportunity for providers to engage in private contracts with patients, and essentially opt out of Medicare and bill the patient. In that case, Tricare will pay benefits there.

It's subject to all the Tricare limitations on payment and so forth, and the beneficiary pays cost sharing. Is basically processed as a Tricare claim. Next slide,

please.

Very brief progress report. I mentioned the Senior Pharmacy benefit. We're filling about 600,000 prescriptions a week under that program. Most of them filled at military facilities, but a substantial number for people who live away from military hospitals in retail pharmacies, and a pretty substantial number through the mail order program that we operate nationally.

I think we probably broke through the 30 million claim level for the first year of operations, which ended earlier this week.

On Tuesday, there was a little celebration back in Washington, where Dr. Winkenwerder and a retired Command Master Sergeant Randy Mix, representing the military coalition, and retired Air Force Major General Dick Murray, representing the Military Veterans Alliance -- the major coalitions, if you will, of beneficiary groups -- all gave some testimony to the impact of this benefit on the retired members and their families and survivors. It really has provided a substantial benefit.

We're pleased that you all are interested in being part of that. It is a very important program to DoD, obviously, because it's this very significant piece of

delivering the benefit.

I'll end with that. We can take questions now, or if you think of some later, we'll all be here to take questions. Yes. I guess you have to go to the podium.

MALE VOICE: A couple, perhaps, more observations than questions of an excellent presentation. The benefit structure, while it appears simple on the surface, three components, it does mean, at least in our experience, you have to evaluate every single service rendered in this program for Tricare coverage.

MR. LILLIE: Right.

MALE VOICE: In other words, your systems have to be able to evaluate the full Tricare benefit structure for every service.

MR. LILLIE: Right.

MALE VOICE: It's a little bit more complex than just simply going in, looking at a Medicare paid claim, and acting as a supplement for any Medicare covered service.

The other observation, or perhaps question, you just brought up other health insurance, and how we have to coordinate with other health insurance. Again, that one gets a little more complicated than it originally appears on the surface.

We do have to take into account the fact that many of these beneficiaries do have, and will maintain Medicare supplements that are employer sponsor plans. We have to take that into account.

As well as, Medicare secondary payer situations, where they have maintained a primary coverage with Medicare. And Medicare acts as a secondary payer, and then there's a very ugly coordination of benefits, transactions, that go on through the claims process stream and cross over, that you do have to worry about.

MR. LILLIE: Right.

MALE VOICE: So a couple of irritations.

MR. LILLIE: Yeah, that's very true on both points. And on the second point, there is the need to -- because Tricare remains the last payer, in those cases, those eventually arise more than likely as paper claims that have to be submitted by the beneficiary after their second payer that they've retained their employer provided insurance, let's say, has adjudicated it.

There is the potential -- and we've run into some problems with duplicates, I think, because practices of Medicare claims processors vary, and in some cases, they shotgun the electronic claim to us and to the other payer.

Other questions? Thank you.

MR. RUBIN: Thanks, Steve. I think the only thing I would add on other health insurance, if you step back and look at the fact that this is a program that we just started from scratch. We haven't got years of history with beneficiaries who over time, who maintain their other health insurance, and updated it, as we would, with our coverages that go on for years and years.

These files, I think, are getting cleaner. Our beneficiaries are becoming better educated in terms of what this benefit will do for them. In fact, one part, during our implementation, we were processing claims that we clearly knew beneficiaries had other health insurance.

We issued EOBs and said, "Had you dropped your other health insurance, here's what would have been paid for you for Tricare for Life," as an education for the beneficiaries.

We've been keeping track of how many beneficiaries are actually coming in and doing maintenance against their OHI files. And there's no question. These files are going to continue to get better. Beneficiaries get smarter, and they're going to make some better decisions, we hope.

Certainly there are situations where beneficiaries

have employer paid other health insurance, and they're not going to drop it at any point in time.

But as we do our crossovers with CMS, we're getting better in terms of the beneficiaries that we are matching, and the information that we're passing to Medicare carriers and intermediaries. So this gentleman had a very valid point about the startup issues under this program.

But I think we need to put that in perspective. We're getting better here, as our beneficiaries become more accustomed to the program.

That's where we've been. And it's important to understand what Steve has explained, to understand our beneficiaries perspective on this.

If you're in the claims business, you don't normally get thank you letters. At least that's been my experience. We have gotten thousands of thank you letters, from beneficiaries, not only for this pharmacy benefit, but for this med/surg benefit.

Obviously it's a huge benefit. I mean, how could you not like this benefit.

But the operational implementation, even though we had a few glitches, went so smoothly that most of our beneficiaries have no clue about some of these issues that

took place, and it has been a very smooth implementation, in large part, thanks to our managed care support partners out there today.

So where we're going in the future, what we're trying to buy in this RFP, we're going to ask Tom Frey to come up. Again, Tom's the Project Officer. When you ask questions through the web, Tom and his team are providing answers.

So today he's going to give you a brief overview, not only a little bit about Tricare, again setting the stage, but also to get into the specific of this RFP. And at the end of Tom's presentation, I urge you to ask any questions.

I'm getting the signal here that we ought to take a break. Must be people in here older than me that need to get out of here. Huh? All right. Let's take a 15-minute break. I've got about 20 till. Let's get back in here at five till, if you would, please. Thanks.

[Break taken.]

MR. RUBIN: Is that working? Will you take your seats, please.

I think what we'll do for our next segment here is, we'll have Tom Frey do his presentation. We'll opt for some questions and answers afterwards.

Doris is then going to talk to us a little bit about

the financial aspects of submitting a proposal. And then we're going to take a break.

Of course, any questions you have for Doris, we'll entertain them while you're here. But I'd like for you all to have an opportunity to step out, think about what we said, and if you have any questions, we can try and take those on. We've two or three written questions, and I'll deal with those when we come back after that break.

So with no further ado here, we'll have Tom come up and talk about the requirements in this new RFP. And as I mentioned before, I think he's going to have a few slides.

A little bit about Tricare in general, again by way of background for folks, and then we'll get into the specifics of the RFP. Tom.

MR. FREY: Thanks, Brian. You may notice I'm all choked up. I'm in the final stages of recuperation from a pretty good cold, so I beg your indulgence on that. Let's go to the first slide. Thanks.

Just by way of a little bit of background, those of you who may be new to our world. You've heard, today, that we have two parts of the military health system: the direct care side, which is the medical centers, hospitals and clinics which are operated by the uniformed services, and the civilian

side purchased care.

The T-NEX concept is intended to integrate those two parts more successfully than they have been integrated in the past. Sometimes the two have operated somewhat independently of each other. Most times benignly; occasionally at cross purposes.

So we're trying to get common goals, common incentives, work toward getting the proper number and mix of patients back into the military facilities, and pick up the rest in the civilian world. That in turn will support force health protection.

On the purchase care side, we're moving away from our old style of RFP, and going more toward the acquisition reform type model. Those of you who are familiar with the way we used to do business in the past know that our request for proposals were very bulky documents that were essentially a "how-to," very prescriptive, and because of their length and complexity were prone to misunderstanding or misinterpretation.

We're trying to change our focus so that we move to a statement of what our top level objectives are, be less prescriptive about mandating processes, and more focused on outcomes. That allows some flexibility on the part of

offerors. And in effect, the offeror completes the statement at work.

They can use their best approach to come up with cost effective solutions, demonstrate to us their knowledge of the subject at hand. They may continue to innovate throughout the period of the contract, and we can take advantage of the lessons that have been learned in private industry, without necessarily imposing what we think is the best way to do business.

We're also trying to shift our focus, in terms of how we manage workload. We're all trying to do more with less these days, so where we've been has been to follow and try and manage a great deal of information and data. And where we're trying to shift to is where we still remain aware of the contract requirements, we track those things that demonstrate trends, and we manage the few things that are really important in determining how well we're doing. Next slide.

You've heard about the managed care support contracts. They're also known as the Health Care and AdMin contracts. These are three regional contracts that cover the United States.

This dual eligible contract is designed as a compliment to those contracts. It covers the 50 United States

and the District of Columbia.

I will interject here that we have gotten a question through the web site as to whether we would also consider including Guam, the Virgin Islands, and Puerto Rico, because Medicare does offer coverage in those areas. That is under consideration, and those of you who have experience with us know that it is not uncommon to see amendments to the RFP. So watch this space.

You heard about a lot of the efforts that went into standing up Tricare for Life, and it was heroic efforts on the part of many people. So now, why are we going to carve it out and make it separate from those successor, three regional contracts?

For one thing, we think that because of the nature of the services that are involved in this particular contract, we may be able to increase competition. And there are all kinds of good things that go along with that. For us, and I think for you as well.

It allows offerors who may have a core competency in claims processing, but not necessarily network development, or QA, or authorizations and referrals, to be a viable player in competing for this contract.

It is a somewhat streamlined claims processing flow,

although you did hear from the floor that there still are Tricare considerations that have to weigh in very heavily.

Also, as Steve Lillie had pointed out, each of our current managed care support contractors had to negotiate crossover agreements with the centers for Medicare and Medicaid services. By going to one dual eligible processing contract, Medicare has to deal with less people, the process is somewhat simplified.

We also heard there are approximately 1.6 million Tricare for Life bene's covered under this program, and who will come under this contract. And there are about 50,000, 52,000 others. Those are the individuals who, prior to the enactment of Tricare for Life, still retained Tricare eligibility, even when they picked up Medicare eligibility. Those are your totally disabled, end-stage renal, spouses of active duty.

Eligibility under the Tricare benefit, and the Tricare benefit is what rules here, is verified through DEERS. As I stated before, we came up with what we think are high level objectives; what we're looking for, that we believe will support the dual eligible FI contract to be successful.

Optimization, as you see it there, means optimization of claims processing and customer service. It

does not mean optimization in the sense that it's used in the managed care support contracts.

We want happy beneficiaries. That's very, very important. We want a seamless transition, or as close to seamless as we can get.

We want a cost-effective approach to the management of this contract that results in the best value to the government, and we want easy and ready access to the data that we need to manage this process, to see where we've been, where we are now, and think about where we might want to be.

The objectives are spelled out in full, in Section C-2 of the RFP. I won't go over them verbatim at this point. The first one is optimized claims and customer service. We want happy bene's; cost effective management approach, as I said; want everything to be ready to go when the bell rings at the start of health care delivery claims processing. And once again, we do want access to the data. We'll go over each of these objectives in a little more detail as I continue here.

First objective: optimize the delivery of claims and customer service. You have heard repeatedly here today that in most cases, because of the very nature of this benefit, we will be second pay to Medicare.

You have also heard that the majority of the claims

that we receive will be received electronically, as crossover claims, from the Medicare processors. As of the end of June, we were running, I think, just shy of 90 percent of all receipts were electronic.

However, you also heard from the floor here. And I was going to emphasize it, if he hadn't brought it up earlier. So thank you. The Tricare Manuals apply.

As Steve pointed out, we did not change the Tricare benefit. So all the provisions, except where specifically waived in the Chapter 22 of the Operations Manual, which is the dual eligible chapter, all the provisions of the Operations Manual, Policy Manual, Reimbursement Manual, Systems Manual, they all apply to this contract.

For this particular contract, the contractor does not underwrite the health care costs. Payment for claims processing is done on the basis of the claim rate. Doris will get into financing more, after I finish here.

Customer service is lumped in as part of a monthly payment for administrative.

The contract does contain performance guarantees. Those of you who are familiar with the managed care support RFPs that are on the street now, are familiar with this provision.

Essentially, it's a quasi warranty that says, "You commit to provide us this level of service or processing." If you are not able to attain that level, then we will withhold an agreed upon amount of money from future payments.

And different from a managed care support contracts, under this dual eligible contract, claims jurisdiction is based on where the care has been received. Not on where the beneficiary resides.

So someone who lives in Europe and goes to Texas to visit the relatives and receives care there, that care will be under the jurisdiction of this contract. If the Texan goes to Europe and gets care there, it is not under the jurisdiction of this contract. So it's a little different set of rules that way.

As we mentioned, the incumbent of this contract, the successful offeror, will be required to negotiate crossover claims agreements with each of the Medicare claims processors. And as Steve had touched on, there are considerations.

The records -- record layouts that you get from these various processors may vary. There's probably going to be a long lead time involved in getting some of these things negotiated, and testing is going to be critical. We would expect that you will have a monitoring plan for seeing how

you're doing on that, and how well you're progressing on standing up.

Steve had also touched on the data match, which takes place between Defense Manpower Data Center, and DEERS, where we send a list of the new accretions to Medicare on a monthly basis. So once again, our database is the database of record for eligibility.

Benefit matrix. This is also a re-run of what you've seen before, but it is very important.

The first line, where something is a covered benefit, under both Tricare and Medicare, our charge, under the statute, is to cover that beneficiary's out of pocket costs. So we will cover any applicable deductible, cost share, balance billing amounts, subject to the Medicare limitations.

We've received a question from the floor that we'll be talking about in a little more detail later on. Goes into that.

Second line. If the service being claimed is not a benefit under Medicare, then the Tricare rules apply. This is not as simple and straightforward as receiving a report on what has been done with the adjudication of a Medicare claim, looking at the outstanding liability and cutting a check for

that amount. The Tricare coverage rules still come into play. That beneficiary will have to satisfy a Tricare deductible and meet any Tricare co-pays.

Third line. If the service being claimed is a Medicare benefit, and not a Tricare benefit, once again, we've got to enforce our rules. We haven't changed our program. We will not make payment, and the beneficiary will be liable for their deductibles and co-pays and any balance billing amounts under the Medicare rules.

And finally the bottom line is pretty self-evident. If it's covered under neither, the beneficiary is out of pocket.

Our second objective. Establish and maintain bene and provider satisfaction to the highest level possible. I won't read all those words there.

What we're looking for here is access on a 24/7 basis with the ability to leave messages and do some kind of automated response type things. We're looking for ability of a caller to talk to a real live human during normal business hours, as they roll across the United States.

These beneficiaries are not cut off from the toll free numbers that the regional managed care support contracts require. They are not excluded from walking into a Tricare

Service Center and getting help. They can go see a beneficiary counseling and assistance coordinator. They just have one more avenue of service and support.

There are a few other -- I don't want to call them cats and dogs -- other items that are included in this contract I just want to touch upon. When program changes happen, we want to shift our focus so that we don't unilaterally just dictate what those changes will be. We are interested in collaborating with our contractors.

So there is a requirement in Section H of this RFP that the successful offeror will participate his requested, in integrated product teams, in developing new requirements.

We're also looking for a quality management plan, and we're looking for quality assurance program that covers every aspect of operations.

Objective number three. Use a cost effective management approach to provide the necessary services, incorporating commercial practices when practicable to attain the best value.

Having said that, "using commercial practices whenever practicable," there are some aspects of Tricare and therefore of dual eligible claims processing that are not very commercial like. As was hammered repeatedly, and we will

hammer it again, the Tricare coverage policy applies. You can't get away from it.

Tricare reimbursement rules will apply. We heard a minor exception for those situations where the service being claimed is a benefit under both Medicare and Tricare. We will cover the full out-of-pocket.

Eligibility has to be determined by a DEERS query. The database of record for deductible information, and catastrophic cap information will reside on DEERS. And it must be updated on DEERS when you've finished processing the claim.

And once you've finished processing the claim, written your claims history, cut a check, you still have to provide a TED record, Tricare encounter data set, to TMA Aurora. That's another difference from the standard commercial world.

Objective number four. All services and systems are fully operational at start of health care delivery. Disruption to beneficiaries must be minimized.

The way that this RFP is structured, as a work load under this contract, will be assumed as each of the existing managed care support contracts over the various current regions are phased out and moved over to the new three-piece

managed care support contracts. The first one of those is scheduled to be Region 11. The RFP says that will be April 1st, '04.

Over a span of seven months, the workload will ramp up until the workload for the whole country has been moved under this contract. We want that to happen as smoothly and transparently as possible.

It may be a little less ugly than some past transitions have been, inasmuch as many of these claims will be crossover claims. It won't be quite a reliant on educating beneficiaries in the change, of where they have to send their claims. But there will still be some pains.

We expect the successful offeror to coordinate with the outgoing contractor to make this transition as smooth as possible. We will want periodic status reports.

We'll be living with you for awhile, seeing how things are going, making very helpful suggestions, and we do expect you to participate in transition meetings with the various players who are going to have a role in this contract.

The outgoing regional contractors are going to have to meet with the new guys, and decide what your working relationships are going to be. There are meetings with DEERS, so on and so forth.

Objective number five. We are interested in ready access to data to support DoD's financial planning, health systems planning, medical resource management, clinical management, clinical research and contract admin.

As I said, what we're looking for there is the ability to go in and grab data that will tell us where we've been, where we are today, how we're doing, and will enable us to do an analysis to consider what direction we might want to take in the future.

As with any system that touches the DoD system, there are security requirements. Those were covered in yesterday afternoon's meeting. I'm not a subject matter on those, but that is a consideration that has to be paid attention to. Next.

Having gone through what we're looking for, I want to just touch briefly what we would like to see in your proposal. This also differs somewhat from the way that we have handled proposal submission in the past, under the old Tricare contracts.

The technical proposal is almost all via oral presentation. Section L has all the gory details on that. But the only written material that is submitted in support of the technical proposal are your oral presentation slides.

And I would like to emphasize here that if you have one particular feature, one or more particular features of your proposal that you believe represents an enhancement over and above what we're asking for, or that exceeds what we're asking for, please put that in writing in your oral presentation slides, because that will be incorporated into any contract that gets awarded. So get that part in writing.

We also are asking for your performance guarantee amounts. Those are covered in Section H, addressed there. And those, obviously, have to be submitted in writing as well.

Past performance, we're only looking for written material on that. Cost proposals, obviously that comes in written as well.

The request for proposals calls for the submission of past performance information 30 days before proposal due dates. There are a number of components of what make up that past performance information.

The first thing we're looking for is your narrative of what your corporate qualifications and experience are. What makes you qualified to meet the requirements of this solicitation. Who are the major players? Who are the customers? And say all this in 25 pages or less.

Another thing that we are looking for, and from here

on, everything that I discuss does not come under the 25-page limit. Please understand that I'm not saying go crazy here.

We are looking for performance reports from those current accounts that you have. We're looking for your five top accounts based on gross revenue. And we want at least three government accounts. So if those top five do not include three government accounts, we'll need more than five.

They can completely overlap, so we only needed five, we could get up to eight, if your top five don't include government accounts. If you don't have three government accounts, just tell us that. We need to know that.

If you don't have five current accounts, you've only got four, tell us that. We won't beat you up on that. We just need to know that.

This particular portion of the past performance package, the offeror is allowed to affix a brief description of the kind of work that they have performed for this account that is giving us this performance report.

The next thing we're looking for is accounts that are no longer active. For those, we're looking for the top three commercial accounts within the last 36 months, which also applied, by the way to the previous ones.

We're also looking for information on the

qualifications and experience of the key personnel for the prime contractor and any first tier subcontractors.

And when I use the word "prime contractor," if there is a consortium, we want to have this information for each of the respective members of that consortium so we can see what kind of talent and skills and experience we're getting here.

What we're looking for is experience that is relevant to the requirements of this particular solicitation. So there's no need to give a complete resume, if some of these things do not directly relate to what we're looking for in this contract.

The final piece of what we're looking for are reports, and we're speaking final reports here, not draft reports that you have not had a chance to respond to yet, but reports that may be issued by state, local, federal, governing or regulatory bodies. If there are no such reports, just let us know that.

We also do reserve, in the RFP, we reserve the right to develop information on our own initiative. That's fairly uncommon, but it could happen.

If we see a headline in the Denver Post that says, "In a scathing report issued Tuesday by the GAO, Yellow Cross of Hackensack, New Jersey, was..." dah, dah, dah, dah, dah, we

reserve the right to use that information and go out and get that report.

So that's just a little bit -- just a high level overview of what we're looking for. What we'd like to see from you. Any questions from the floor? Sir.

MALE VOICE: In the L-4, you're asking also for some type of narrative to go along with those to explain the relationship of the account. I'm unclear on the L-5, if you're looking for the same type of narrative.

MR. FREY: Let me go get my RFP.

MALE VOICE: Yeah. The L-5 is the past accounts, the accounts you no longer have. The L-4 is the current.

MR. FREY: What we're looking for is enough information to understand what kind of work you did for these entities, and how it relates to the requirements of this solicitation. If that doesn't answer what you're asking, let me know that, and we'll try and do better.

MALE VOICE: I guess what I'm asking is, that you're very specific on the current accounts that you also want a narrative to go along with that, that explains the relationship of the account. But you're -- it's less clear, and especially with some of the recent questions that have come up, whether or not you want that on the past accounts.

MR. FREY: Okay. Yeah. We don't have a prohibition on that. And actually on the current accounts, it's not so much a requirement as a permissive type thing. You can do that if you wish.

If in fact we do not want that kind of information, I'll confer with my colleagues here and we'll put that out in the web site.

MALE VOICE: Thank you.

MR. FREY: Anyone else?

MR. RUBIN: If I may jump in here. Clearly it's in the best interest of the offeror to tell us the good stuff that's taking place with your current contracts. And if there's any explanation on terminated contracts.

There's contracts that just terminate, period, for nothing related to performance. And there are contracts that may have terminated as a result of a performance issue. And I think that's all we're looking for in that.

Certainly, it's in your best interest to explain as much of that to us as you can, and not leave us to try and guess what your experience might have been with a particular account.

MALE VOICE: Thank you.

MR. RUBIN: Okay. Thanks, Tom. I just made a

couple of notes here. If you're in the claims processing business, you understand when something is of a benefit or is not a benefit. But if you want to peel this back a little bit, certainly under Medicare, Medicare has limitations. It could be a benefit that's expired or we've reached this limitation, at which time the Tricare benefit would kick in as prime.

I don't know what the experience is under Medicare, but there are days and dollar limits on many of their services that do not apply to our program. And certainly Medicare denies claims for lack of medical necessity. It's a benefit, but they're not paying it.

We're not about to jump in and say, "Yeah, we think it is medically necessary," and start paying that claim as prime. Again, we're going to follow the Medicare lead there.

But again, if you're in the business, that's not news to you, but I did want to touch on that a little bit.

Okay. Thanks, Tom. Nice presentation. Appreciate that. At this time, I'd like to have Doris come back up and talk about the finances here a little bit.

MS. NAVARRO: Thank you, Brian. With regard to pricing, this will be a requirement type contract with firm, fixed price elements.

Offerors will be required to complete Section B. This includes a firm, fixed, transition in price for transitioning of the former regions to the successor contract, a fixed unit rate price for both electronic and paper claims processing.

The estimated quantities that we have in the RFP will be used for evaluation purposes only. You develop what you feel is the appropriate rate.

A fixed price, monthly price for administration. These are costs that are not included in your claims processing rate, and a firm, fixed transition out price for each option period.

Prices will then be evaluated for reasonableness. The total evaluated price will consist of the summation of the proposed fixed prices with the exception of the transition out prices. Only the highest transition out price will be included in the total evaluated price.

Information, other than cost in pricing data is required. This includes any data that you have to support your price.

This information will be used in evaluating cost realism. Cost realism analysis results will be used to assess the offerors proposal risk. Next slide.

With regard to financial responsibility, you must demonstrate adequate financial resources, or be able to obtain such in order to perform the contract. I will focus on your financial ability to perform this contract.

I need you to furnish whatever type and depth of financial and other information you have to establish your financial capability, or disclose your financial condition. We are only requesting information that is necessary for the protection of the government's interest.

The government will review the financial data submitted. Any unwillingness or inability to present reasonably requested information in a timely manner, especially information that a prudent business person would be expected to have and use in the professional management of a business may be a material fact in our determination of the contractors responsibility and prospects for contract award. I will then review the information provided in order to determine the offeror responsibility. Next slide.

With regard to the subcontracting plan, you will be required to submit a subcontracting plan. We cannot award a contract unless the subcontracting plan provides the maximum, practicable opportunity for small business concerns, as required by FAR 52.219-9. This is also known as our best

efforts clause.

The plan must include a percentage goals for the utilization of small businesses as subcontractors. Subcontracting plan is required to contain eleven elements. And those, you will find a detailed outline in FAR 52.219-9(d).

Also the Small Business Administration is available to provide assistance to other than small businesses on how to prepare their subcontracting plans. They can also counsel small businesses on how to market their products and services to the prime contractors.

We look forward to receiving your proposals, and those proposals are due on November 27th. Thank you very much. Do you have any questions?

MALE VOICE: Hi, Doris. The question is, and when you're talking about the administrative fee, that administrative fee is -- we're seeing no opportunities to adjust that administrative fee for the length of the contract. Once it's bid in the offeror's proposal, it's pretty much written in granite for the length of the proposal.

Unlike the claim fee, where you have a paper or electronic fee, if the volume is increased dramatically, the offeror is at least receiving some type of recompense

for that.

This is unlike the managed care support contract T-NEX solicitation that reduces the offeror risk by allowing for six month adjustments to a per member, per month calculation, instead of that administrative fee.

Would TMA consider allowing for periodic adjustments to either the administrative fee, or adopt an adjustable per member, per month, as done in the other solicitations.

MR. RUBIN: We'll look at that, Kevin. I think the difference in the contracts here is, we've got beneficiaries that move all over the country, which could have impacts on the eligibles that are served by a single managed care support contract. This is a national contract. Wherever they go, they're still our beneficiary.

Now you're talking about adjustments in people aging in to this. And we'll think about -- I'll be honest with you, I haven't had any discussions with folks on that. Haven't seen it as a problem or an issue, but we'll certainly look at it.

MALE VOICE: Yeah, I understand your comment, Brian. It seems that when we talked about the -- when Steve broached the aging populations and talked about the dynamics in that, that there is some potential there for some risk on the

contractors if those calculations over the term of this contract aren't necessarily made that precisely. There could be some pretty significant cost ramifications to the offeror. Thank you.

MR. RUBIN: Okay. We'll say this, again, later, too. It would be very helpful, Kevin, if you could put a paragraph and put it on the web to us. And if you have any recommended language, we'd be happy to look at that, too. And again, I'll say this later.

We have not closed off questions coming in through the web. But this is not going to go one forever, and you can guess this is going to happen very quickly. So I encourage you, if you have comments or questions like that, even after this session, please get them in on the web site to us. Any other questions for Doris?

MALE VOICE: Just a question about the Option Year One claim volumes that are in Section B of the RFP. It appears upon examination, it doesn't take into account the transition schedule of the various contracts into the new TDEFIC contract. There's a full year's volumes there that kind of looks like the base and the schedule ought to be less than that.

MS. NAVARRO: I think Tom has this.

MR. FREY: I will say this: those estimates are being revisited, even as we speak. And in the not unlikely event of an amendment, you might see some changes there.

MALE VOICE: I think that means, "We're looking at that."

MR. RUBIN: Any other questions for Doris? Thank you, Doris.

MS. NAVARRO: Thank you.

MR. RUBIN: Okay. We've received two or three written questions, I think, that I haven't had a chance to look at. And we're going to do that now. So let's take a 15-minute break. We'll be back here at five till.

Give you a chance to think about what you've heard. And if we don't have a lot of questions, you'll probably be out of here by 11:30 easily. Thank you.

[Break taken.]

MR. RUBIN: If we could take our seats, please. Okay. We've got a lot of good questions. And I've added a member to our panel up here. Mr. Mike Carroll.

Mike is the Project Officer for the managed care support contracts, and some of the questions we've received today go back and forth between TDEFIC and Managed Care. So I've asked Mike to sit in.

We've got quite a few questions, and I admit we haven't had an opportunity to go back and look up all the language in the RFP. So we will give you today what we think the answer is, and then we'll go back and make sure the RFP says the same thing. There may be a couple situations where we're going to have to make some changes. So let me begin.

"Is it the responsibility of TDEFIC to send electronic claims received from Medicare to a beneficiary's other health insurance, or will Medicare send the claim directly to OHI?"

It's not the TDEFIC's responsibility to be sending claims to other health insurance.

"Is it the responsibility of the beneficiary or provider to get claims for benefits not covered by CMS to the TDEFIC?"

I think that's a "yes and no" answer. I mean, if a claim comes in to Medicare, and they're denying the coverage, we expect to get an electronic record. If somebody makes a determination up front, and not even send a claim to Medicare, then the beneficiary provider is going to have to send us a paper claim. So that's a yes/no answer there.

"How many of today's electronic claims are proving difficult for the managed care support contractors to

translate into TEDs due to a lack of data?"

Well, first of all, TEDs doesn't even apply, to date, to these contracts. But if you look at HCSRs, we're not having any problems in that respect. There's enough data on these claims to build a HCSR record.

"It was stated that 90 percent of claims are currently submitted electronically. What type of claims make up the remaining ten percent?"

It's our guess that a majority of those are when we are the third payer in line; Medicare being first, there being a secondary payer ahead of us, that Medicare may or may not already be doing a crossover claim. And then we're third in line.

If anybody has any better explanation there, please let me know, but we think that's what's happening with this other ten percent. Kevin, do you -- can you speak up a little there, Kevin?

MALE VOICE: Another example could be when you have a Medicare/HMO, like a Plus/Choice type plan, and that access the Medicare plan, but they don't actually submit claims through the regional Medicare carrier. Then you might get claims for cost shares directly from the beneficiaries, and you have to know that's a Medicare Plus/Choice plan.

MR. RUBIN: Thanks, Kevin. I appreciate that.

This is a question of past performance, and this person says, "I asked this also in T-NEX, and got the answer that you wanted relevant experience."

The question is, "Some of our top accounts by gross revenue are not those accounts relevant to this procurement. Would you prefer to have relevant past experience for TDEFIC, or largest accounts by gross revenue?"

We're going to go back and look at the language. I mean, we want to top five relevant accounts by gross revenue. And if we're not saying that properly, we will go back and take another look at that. We are -- we will be consistent between this RFP and the managed care support contract.

"Should there be only one bank account for which all claim payments will be made?"

I think the answer to that is "Yes." I don't know what we require in the RFP. We haven't had a chance to look it up, but we will go back and take a look at that.

"Please discuss any restrictions or limitations associated with prime/subcontract participation in TDEFIC, and participation in any other T-NEX contract, e.g., managed care support, retail pharmacy, audit, et cetera."

This requires a little explanation. The managed care support RFP that's on the street limits the number of regions a contractor may be awarded, that the prime may receive. You can receive an award under that contract, and still be the winning bidder under this contract. There are no limitations there.

This question starts getting a little more dicey when you throw in "audit." If you're suggesting can you win the audit contract that's going to audit yourself as the winner of another contract, you can pretty much guess what I'm going to say, but I think that's probably going to be the exception.

"Please describe the delineation of customer service responsibility for dual eligible beneficiaries between the T-NEX managed care support contract, TDEFIC and retail prescription contractors."

I think what this is getting to is the notion that we're trying to provide the best customer service that we can to these folks. And the fact that we're carving this out of the managed care support contracts doesn't mean we don't expect the managed care support contractor to try and answer questions that a beneficiary may have, an over beneficiary may have, as they come into the Tricare Service Center.

You can take it as far as you can go with that. At some point, your customer service folks run out of information, if you're talking about specific claims data.

Conversely if the over-65 beneficiary calls into you wanting to talk about prescription drug coverage, we expect you to provide as much information as you can to that beneficiary about what their benefits are. We know you don't have access to the claims information if it gets to that point. So this information back and forth, we expect, basically whoever picks up that telephone to take some responsibility for providing that beneficiary with the best service they can.

Again, these are our seniors, and we're going to be getting a lot of this. We get it today, it's working well today. This carve-out will create a little different dynamic, but it still doesn't mean that there's not ownership for all our contractors that receive calls.

"Does the government desire to have a dual-eligible customer contact result..." Oh, I just answered that question. Yes, we do.

"During Mr. Frey's brief, it appears he stated that all that was required was oral presentation slides, written past performance and a written price proposal narrative.

Please clarify the exact requirement for need or requirement of a written narrative proposal to accompany the oral presentation slides." Tom, I'll let you take that one.

MR. FREY: What we're looking for here is your oral presentation slides, your performance guarantees and your standards that you propose to hold yourself to. And that is pretty much all we're looking for in writing.

As long as I have the microphone here, I would like to clarify a misstatement that I made in my slides. When I discussed qualifications of key personnel, I discussed that under the heading of past performance. That's where it used to reside, but it never hit the street that way.

That is now found under cost effective management approach in Section L-14.5.1.3.5. So we will expect that to be covered during oral presentations.

MR. RUBIN: Lot of dots in there.

"The Tricare Ops Manual, Chapter 22, Section 5, 2-1 states interface meetings for transitioning should include MEMSO and CHCS. Could you elaborate on the role of MEMSO and CHCS in the TDEFIC?"

We're going to put this under good catch, and that will be coming out.

"Does the government anticipate TDEFIC beneficiaries

will receive care in CHAMP VA facilities? If so, what are the payment rules the contractor must follow in those cases?"

Well, first of all, Medicare doesn't pay in VA facilities. Our rules apply as prime. The VA would bill us as any provider would.

"When a provider does not accept assignment with Medicare, they may sometimes be limited to 115 percent reimbursement of Medicare allowable, and at other times, can bill in excess of 115 percent."

I'm learning something here myself. I guess there are different provisions, depending on the provider.

"The Medicare rules on this vary by contractor. How does the government anticipate the TDEFIC contractor determine the appropriate levels of payment to insure beneficiaries are made whole?"

And I think the best answer we can give here, and there's a lot of history that we have learned, as we went into TFL, thinking that Medicare carriers and intermediaries did the same thing, thinking they have the same benefit, we found out that was not true.

The only thing I can say in answer to this is, as you negotiate with the carriers and intermediaries on those crossover claims, this particular issue is going to have to be

discussed with each of those folk to find out if they're doing something different among themselves.

We do not have information here in terms of what each carrier and intermediary is doing. And I have no idea how pervasive a problem that is. Quite frankly, I've not heard of that, in our year's implementation. But evidently it's going on somewhere, at least a time or two. Steve?

MR. LILLIE: Yeah. The point here goes back to the statutory requirement to pay out-of-pocket costs, which then comes not to what the provider happens to have billed, but whatever legal liability for the patient exists, after Medicare finishes paying. And that may well vary.

There are some kinds of providers that don't have a limit on the amount that they can bill, and in that case, Tricare's responsibility paying the out-of-pocket costs to the beneficiary would extend up to the billed amount.

For the most part, for physicians and other professional providers, the limitation is the Medicare limiting charge of 115 percent of 95 percent of the Medicare allowable in the location. But there are potential variations.

And as Brian says, if there's different practices, that's the kind of thing that you're going to have to ferret

out as you go along in talking with these FIs and carriers.

MR. RUBIN: Thank you, Steve. Don't put that mic too far away.

"Mr. Lillie stated, Tricare is primary payer for services provided to a TFL beneficiary by a provider who opts out of Medicare. Is the TDEFIC contractor responsible for that claims payment, or is the regional managed care support contractor responsible for paying that type of claim?"

MR. LILLIE: It's this contract, the dual eligible one.

MR. RUBIN: "If the claims payment requirement is to act as secondary payer, with claims received directly from Medicare, what are the circumstances under which the..." This is IBCP, which I had to look up, "...Internet Based Claims Processing would be used?"

I think that's a good catch. That's a carry over from something we're doing in the managed care support contracts. I don't have an answer in terms of how this would be used. And I think you can assume we're going to be taking that requirement out.

"When do you anticipate you will have service call volume projections so offerors can evaluate scale of the service requirement?"

I think we have told you everything we know about call volumes. We've given gross numbers, as I understand it, in some of the backup information. We don't necessarily have breakouts on phone calls, between those that are Medicare or dual eligible, versus our other Tricare users.

So I think our answer right now is, we've given you what we have. But we will go back and take another look at that.

And if whoever generated that would like to elaborate on that in a question on the web site, I would appreciate that.

That's kind of followed -- we have a different author here, but a similar question. "Can you provide projected claims volume by type? Part A, inpatient; Part A, outpatient, and Part B?"

And I think we can, but I'm not going to give an affirmative here. We're going to go back and take a look at it. If we've got it, we'll give it to you. There's nothing that benefits any of us by holding back information. So if we can find it, we'll put it on the web site, or via an amendment, whatever Doris tells us to do. Probably both.

"Currently, are Part A claims passed to contractors electronically?"

I think the answer is "Yes."

"Is it necessary for contractors to contract with Medicare carriers in intermediaries specifically for Tricare for Life, or can existing agreements that contractor has in place for its commercial business be used?"

I think our answer is going to be to that to use your commercial. If it gets what we need, if we get that claim, I don't think we're hung up on any contract formats.

I don't think we provided any when we stood this up before, and left that to the discretion of the existing managed care support contractor. So I think you're going to get a "yes," to this one.

"Will the contractor be responsible for enrollment processing for Tricare Plus?"

And the answer to that is "No." It's covered under the managed care support contracts.

"And our prescription claims for the Tricare for Life population included in this contract -- and when I read this, I jumped out there and said "No." But I think it needs some clarification, and I've asked Mike to take that on.

MR. CARROLL: For the most part, the answer is "No." But there are exceptions. And you have to be very careful and watch the web site for what the Tricare Mail Order Pharmacy

pays for, and in the near future, you'll see the Tricare Retail Pharmacy.

Essentially, though, for your planning purposes, if a script is not obtained from a retail pharmacy, or it's not obtained from the mail order, then you will be responsible for processing it.

Examples: home infusion therapies that are provided by a home health care agency. You would be responsible for paying for that drug. Some drugs that are administered within a physician's office. It's a drug claim, or at least a line item on a claim that you would be responsible for paying for.

These are small volumes, but you do have to build your systems to be able to accommodate them.

MR. RUBIN: Okay. Thank you, Mike.

That's the end of our written questions. Have our answers generated any questions, or has anybody thought of anything that we don't have in writing that you would like to ask at this time? Okay.

FEMALE VOICE: I was still writing, so I didn't mine on a card. Can you explain the authorization process between a managed care support contractors and the dual eligible contractor, and the military and dual eligible contractor, specifically because of NAS?

MR. RUBIN: Mike, can I ask you to take that?

MR. CARROLL: Doesn't exist. It's just that simple. There is no crossover of authorizations between contractors. There's no authorization requirement, with the exception of inpatient mental health, which is a statutory requirement for care under the dual eligible contract.

FEMALE VOICE: Okay. But on NAS, there -- within Chapter 22, it says that a NAS is required. And I heard yesterday that the NAS was going to be sent to us by the military's authorization system.

MR. RUBIN: We usually call it an N-A-S, but --

FEMALE VOICE: N-A-S.

MR. CARROLL: We need to correct Chapter 22. There will be no non-availability stance.

FEMALE VOICE: Okay. Thank you. So that means that on the inpatient mental health, the dual eligible contractor is responsible for -- is it retrospective review, or is it pre-authorization before someone goes into an inpatient facility?

MR. CARROLL: The requirement is pre-authorization.

FEMALE VOICE: Okay. Because I think there's a statement in Chapter 22, also, about retrospective review.

MR. CARROLL: Since I can't visualize that right

now, I can only promise you that we'll take a look.

FEMALE VOICE: Okay. All right. Thanks.

My second question is, what instructions are being provided to the managed care support contractors currently for the transition of data, for non-TFL bene's?

Specifically, TFL claims are very easy to identify.

However, the current managed care support contractors have been processing claims for the other population of dual eligibles, specifically the under 65. What instructions are being provided to them, to transition those claims and those claims only, or how will they be identified to be provided to the dual eligible contractor?

MR. CARROLL: Tom, do you want to take this, or do you want us to? What I'd like to do is refer you to the operations manual to the transition chapter --

FEMALE VOICE: Mm-hmm.

MR. CARROLL: -- that identifies what the requirements are.

Basically what it says is, you'll meet within "X" number of days, three I think it says, following award to develop a detailed transition plan.

And the existing managed care contractors will

transition the history to the appropriate new T-NEX contractor, whether it's TDEFIC or the new managed care support contractor.

FEMALE VOICE: I guess my question is, how does the outgoing know which claims or which beneficiaries need to go which place?

MR. CARROLL: Oh, from their internal records.

FEMALE VOICE: Okay. But if eligibility is based specifically on DEERS, it may not be in that claim record.

MR. CARROLL: Payment type is in that claim record.

FEMALE VOICE: Which payment type are you referring to?

MR. CARROLL: That it was paid as a TFL claim that's in that record.

FEMALE VOICE: Okay. I'm talking about non-TFL claims. Today's TFL contract only includes over 65.

The new dual eligible contract includes under 65 beneficiaries. I'm concerned about those claims for those people.

MR. CARROLL: The 50 thousand?

FEMALE VOICE: Yes.

MR. CARROLL: Off the top of my head, I can't answer you. We'll have to go take a look.

FEMALE VOICE: Okay.

MR. CARROLL: Tom, do you remember? We'll have to go take a look.

FEMALE VOICE: Okay. And my last --

MR. RUBIN: Well, we know who they are from the DEERS eligibility. It can't be that hard, if we're talking about trying to do that match. I understand where you're going with that. We'll look into that.

FEMALE VOICE: All right. My last question is, is there an expectation of the incoming contractor to have all HCSR data for these claims coming in, available for adjustments for TEDs?

In other words, does the incoming contractor have to maintain a HCSR data base, and a TED data base?

MR. RUBIN: Where's Pete?

MR. FREY: I believe the answer to that has to be yes. You've got to be able to process adjustments, previous claims.

MR. RUBIN: Could you put that question in writing? I'm not sure that's the answer that I would give.

We heard yesterday on the duplicate claims that there is some need to be able to read a HCSR record, for up to three or four months, I think I heard. Is that what you're

asking, or is there more to that question?

FEMALE VOICE: No. I understand the requirement to adjust a TED -- to create a TED adjustment record to a previous HCSR record. My question is, does that lend itself toward the incoming contractor having to maintain HCSR data to have it available to do the TED adjustments.

MR. RUBIN: Okay. I think the answer to that is yes. John, did you have -- okay. Thank you.

FEMALE VOICE: Thank you.

MALE VOICE: Hi, Brian. I've got a question following up from yesterday's presentation, Capt. Kelly, from Tricare Online. Is there any language in TDEFIC that talks about a web presence on TOL? I didn't see that yesterday in his presentation.

MR. RUBIN: I see some head shaking. I think we're going to have to look. I don't think there is. Nothing that I'm aware of, Mike, but we'll look.

MALE VOICE: Okay. Yeah. These are more clarifications than they are questions.

The other thing is, I didn't see a lot specifically addressing a handoff of a call from a managed care support contractor to the TDEFIC contractor. Is there envisioned any mechanism there on one side or the other side, either the

managed care support side or on the TDEFIC side, so that it's a seamless transition for the beneficiary?

MR. RUBIN: Well, if it's not in there, one thing that's going to be in there is a requirement for an MOU between the winner of this contract, and each of the managed care support contracts. And I think that can play itself out in a couple of ways.

I mean, if you're at a service center at an MTF, even though the managed care support contractor there may not have access to TDEFIC claims information, the BCAC certainly does, who may be a few steps down the hall. There's certainly a way to help the beneficiary there.

Or it may be, "Here's the 800 number," or "Here's some other avenue."

I expect there are different opportunities there, and we expect that to be spelled out in the MOU between these prime contractors, so a bene doesn't get lost. Go ahead, Tom.

MR. FREY: Yeah, I'd also just like to add that although we don't have a specific requirement for a particular way to do a handoff, or a referral, you should keep in mind that if you have something in mind that you believe would be an enhancement, you may want to sell it that way in your proposal.

MALE VOICE: Okay. Thank you very much.

MR. RUBIN: And that requirement for an MOU is a good catch we got by the services, and that's being mandated into Mike's contracts as well, so it's on both sides here. Any other questions, comments?

Okay. Well, Doris is going to close this out here, but I want to thank you all on my behalf here, and the rest of our panel for your participation today. We really appreciate you being out here.

We look forward to your proposals. If there's anything we can do between now and the proposal submission date to help, please let us know, and don't wait on getting your questions submitted on the web, because we're going to be closing this out here before long. Thank you.

MR. NAVARRO: Thank you, Brian. In closing, I would like to remind everyone that the RFP is located on the web site. That general information sheet that you now see is included in the folder that you picked up.

This includes the FedBizOps announcements, the Tricare Manuals, any questions and answers, the preproposal conference transcripts and any slides that you saw today. Next slide.

The primary points of contact is me, Doris Navarro,

the contracting officer, and Scott Moore, the contract specialist.

I would like to thank Mr. Rubin, and the panel members, and the speakers. And I want to thank you all for attending and participating at this conference. And again, I look forward to receiving your proposals. Thank you very much. And that concludes our preproposal conference.

C E R T I F I C A T E

STATE OF COLORADO)
) ss
COUNTY OF ARAPAHOE)

I, Laura M. Machen, an independent transcriber and notary public within and for the State of Colorado, certify the foregoing transcript of the tape recorded proceedings, **In Re: TRICARE DUAL ELIGIBLE FISCAL INTERMEDIARY CONFERENCE, October 3, 2002**, and as further set forth on page one, is reduced

by computer transcription, and dependent upon recording clarity, is true and accurate, with special exceptions of precise identification of any or all speakers and/or correct spelling of any given or spoken proper name or acronym.

Dated this 10th day of October, 2002.

My commission expires May 23, 2004.

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